Calendar No. 453

103D CONGRESS
2D SESSION

S. 2122

To improve the public and private financing of long-term care and to strengthen the public safety net for elderly and non-elderly disabled individuals who lack adequate protection against long-term care expenses, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 17 (legislative day, MAY 16), 1994

Mr. COHEN introduced the following bill; which was read the first time

JUNE 7, 1994

Read the second time and placed on the calendar

A BILL

To improve the public and private financing of long-term care and to strengthen the public safety net for elderly and non-elderly disabled individuals who lack adequate protection against long-term care expenses, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Public/Private Long-Term Care Partnership Act of 1994''.

(b) TABLE OF CONTENTS.—The table of contents is as follows:

TITLE I—TAX TREATMENT OF LONG-TERM CARE INSURANCE

SEC. 101. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by striking subparagraph (C), and by inserting after subparagraph (B) the following new subparagraphs:

''(C) for qualified long-term care services (as defined in subsection (f)),

''(D) for insurance covering medical care referred to in—

''(i) subparagraphs (A) and (B), or

''(ii) subparagraph (C), but only if such insurance is provided under a qualified long-term care insurance policy (as defined in section 7702B(b)) and the deduction under this section for amounts paid for such insurance is not disallowed under section 7702B(d)(4), or

''(E) for premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged.''

(b) QUALIFIED LONG-TERM CARE SERVICES DEFINED.—Section 213 (relating to the deduction for medical, dental, etc., expenses) is amended by adding at the end the following new subsection:

''(f) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, curing, mitigating, treating, preventive, therapeutic, and rehabilitative services, and maintenance and personal care services (whether performed in a residential or nonresidential setting), which—

''(A) are required by an individual during any period the individual is an incapacitated individual (as defined in paragraph (2)),

''(B) have as their primary purpose—

''(i) the provision of needed assistance with 1 or more activities of daily living (as defined in paragraph (3)), or

''(ii) protection from threats to health and safety due to severe cognitive impairment, and

''(C) are provided pursuant to a continuing plan of care prescribed by a licensed professional (as defined in paragraph (4)).

''(2) INCAPACITATED INDIVIDUAL.—The term 'incapacitated individual' means any individual who has been certified by a licensed professional as—

''(A) being unable to perform, without substantial assistance from another individual, at least 2 activities of daily living (as defined in paragraph (3)),

''(B) having moderate cognitive impairment as defined by the Secretary in consultation with the Secretary of Health and Human Services, or

''(C) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in subparagraph (A).

''(3) ACTIVITIES OF DAILY LIVING.—Each of the following is an activity of daily living:

''(A) Eating.

''(B) Toileting.

''(C) Transferring.

''(D) Bathing.

''(E) Dressing.

''(F) Continence.

''(4) LICENSED PROFESSIONAL.—

''(A) IN GENERAL.—The term 'licensed professional' means—

''(i) a physician or registered professional nurse,

''(ii) a qualified community care case manager (as defined in subparagraph (B)), or

''(iii) any other individual who meets such requirements as may be prescribed by the Secretary after consultation with the Secretary of Health and Human Services.

''(B) QUALIFIED COMMUNITY CARE CASE MANAGER.—The term 'qualified community care case manager' means an individual or entity which—

''(i) has experience or has been trained in providing case management services and in preparing individual care plans;

''(ii) has experience in assessing individuals to determine their functional and cognitive impairment; and

''(iii) meets such requirements as may be prescribed by the Secretary after con-

sultation with the Secretary of Health and Human Services.

''(5) CERTAIN SERVICES NOT INCLUDED.—The term 'qualified long-term care services' shall not include any services provided to an individual—

''(A) by a relative (directly or through a partnership, corporation, or other entity) unless the relative is a licensed professional with respect to such services, or

''(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term 'relative' means an individual bearing a relationship to the individual which is described in paragraphs (1) through (8) of section 152(a).''.

(c) TECHNICAL AMENDMENTS.—Paragraph (6) of section 213(d) is amended—

(1) by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)'', and

(2) by striking ''paragraph (1)(C) applies'' in subparagraph (A) and inserting ''subparagraphs (C) and (D) of paragraph (1) apply''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 102. TREATMENT OF LONG-TERM CARE INSURANCE.

(a) GENERAL RULE.—Chapter 79 (relating to definitions) is amended by inserting after section 7702A the following new section:

"SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE.

''(a) IN GENERAL.—For purposes of this title—

''(1) a qualified long-term care insurance policy (as defined in subsection (b)) shall be treated as an accident and health insurance contract,

''(2) any plan of an employer providing coverage under a qualified long-term care insurance policy shall be treated as an accident and health plan with respect to such coverage,

''(3) amounts (other than policyholder dividends (as defined in section 808) or premium refunds) received under a qualified long-term care insurance policy (including nonreimbursement payments described in subsection (b)(6)) shall be treated—

''(A) as amounts received for personal injuries and sickness, and

''(B) as amounts received for the permanent loss of a function of the body and as amounts computed with reference to the nature of injury under section 105(c) to the extent that such amounts do not exceed the dollar amount in effect under subsection (g) for the taxable year,

''(4) amounts paid for a qualified long-term care insurance policy described in subsection (b)(6) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

''(5) a qualified long-term care insurance policy shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

''(b) QUALIFIED LONG-TERM CARE INSURANCE POLICY.—For purposes of this title—

''(1) IN GENERAL.—The term 'qualified long-term care insurance policy' means any long-term care insurance policy that—

''(A) limits benefits under such policy to incapacitated individuals (as defined in section 213(f)(2)), and

''(B) satisfies the requirements of paragraphs (2), (3), (4), and (5).

''(2) PREMIUM REQUIREMENTS.—The requirements of this paragraph are met with respect to a policy if such policy provides that premium payments may not be made earlier than the date such payments would have been made if the policy provided for level annual payments over the life expectancy of the insured or 20 years, whichever is shorter. A policy shall not be treated as failing to meet the requirements of the preceding sentence solely by reason of a provision in the policy providing for a waiver of premiums if the insured becomes an incapacitated individual (as defined in section 219(f)(2)).

''(3) PROHIBITION OF CASH VALUE.—The requirements of this paragraph are met if the policy does not provide for a cash value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed, other than as provided in paragraph (4).

''(4) REFUNDS OF PREMIUMS AND DIVIDENDS.—The requirements of this paragraph are met with respect to a policy if such policy provides that—

''(A) policyholder dividends are required to be applied as a reduction in future premiums or

to increase benefits described in subsection (a)(2),

''(B) refunds of premiums upon a partial surrender or a partial cancellation are required to be applied as a reduction in future premiums, and

''(C) any refund on the death of the insured, or on a complete surrender or cancellation of the policy, cannot exceed the aggregate premiums paid under the policy.

Any refund on a complete surrender or cancellation of the policy shall be includable in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

''(5) COORDINATION WITH OTHER ENTITLEMENTS.—The requirements of this paragraph are met with respect to a policy if such policy does not cover expenses incurred to the extent that such expenses are also covered under title XVIII of the Social Security Act.

''(6) NONREIMBURSEMENT PAYMENTS PERMITTED.—For purposes of subsection (a)(4), a policy is described in this paragraph if, under the policy, payments are made to (or on behalf of) an insured individual on a per diem or other periodic

basis without regard to the expenses incurred or services rendered during the period to which the payments relate.

''(c) TREATMENT OF LONG-TERM CARE INSURANCE POLICIES.—For purposes of this title, any amount received or coverage provided under a long-term care insurance policy that is not a qualified long-term care insurance policy shall not be treated as an amount received for personal injuries or sickness or provided under an accident and health plan and shall not be treated as excludable from gross income under any provision of this title.

''(d) TREATMENT OF COVERAGE PROVIDED AS PART OF A LIFE INSURANCE CONTRACT.—Except as otherwise provided in regulations, in the case of any long-term care insurance coverage (whether or not qualified) provided by rider on a life insurance contract, the following rules shall apply:

''(1) IN GENERAL.—This section shall apply as if the portion of the contract providing such coverage is a separate contract or policy.

''(2) PREMIUMS AND CHARGES FOR LONG-TERM CARE COVERAGE.—Premium payments for long-term care insurance policy coverage and charges against the life insurance contract's cash surrender value (within the meaning of section 7702(f)(2)(A)) for

such coverage, shall be treated as premiums for purposes of subsection (b)(2).

''(3) APPLICATION OF 7702.—Section 7702(c)(2) (relating to the guideline premium limitation) shall be applied by increasing, as of any date, the guideline premium limitation with respect to a life insurance contract by an amount equal to—

''(A) the sum of any charges (but not premium payments) described in paragraph (2) made to that date under the contract, reduced by

''(B) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702(f)(1)).

''(4) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for charges against the life insurance contract's cash surrender value described in paragraph (2), unless such charges are includable in income as a result of the application of section 72(e)(10) and the coverage provided by the rider is a qualified long-term care insurance policy under subsection (b).

For purposes of this subsection, the term 'portion' means only the terms and benefits under a life insurance contract

that are in addition to the terms and benefits under the contract without regard to the coverage under a long-term care insurance policy.

''(e) PROHIBITION OF DISCRIMINATION.—

''(1) IN GENERAL.—Notwithstanding subsection (a)(3), any plan of an employer providing coverage under a qualified long-term care insurance policy shall qualify as an accident and health plan with respect to such coverage only if—

''(A) except as provided in paragraph (2), the plan allows all employees to participate, and

''(B) the benefits provided under the plan are identical for all employees that choose to participate.

''(2) EXCLUSION OF CERTAIN EMPLOYEES.—For purposes of paragraph (1), there may be excluded from consideration—

''(A) employees who have not completed 3 years of service;

''(B) employees who have not attained age 25;

''(C) part-time or seasonal employees; and

''(D) employees who are nonresident aliens and who receive no earned income (within the meaning of section 911(d)(2)) from the em-

ployer which constitutes income from sources within the United States (within the meaning of section 861(a)(3)).

''(3) APPLICABILITY.—The provisions of this subsection shall not apply to any plan of an employer providing coverage under a qualified long-term care insurance policy until the Secretary of Health and Human Services certifies to the Secretary that provisions that are substantially similar to the provisions of this subsection apply to all health benefit plans.

''(f) EMPLOYER PLANS NOT TREATED AS DEFERRED COMPENSATION PLANS.—For purposes of this title, a plan of an employer providing coverage under a qualified long-term care insurance policy shall not be treated as a plan which provides for deferred compensation by reason of providing such coverage.

''(g) DOLLAR AMOUNT FOR PURPOSES OF GROSS INCOME EXCLUSION.—

''(1) DOLLAR AMOUNT.—

''(A) IN GENERAL.—The dollar amount in effect under this subsection shall be $150 per day.

''(B) INFLATION ADJUSTMENTS.—In the case of any taxable year beginning in a calendar

year after 1996, the dollar amount contained in subparagraph (A) shall be increased by an amount equal to—

''(i) such dollar amount, multiplied by

''(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, by substituting 'calendar year 1995' for 'calendar year 1992' in subparagraph (B) thereof.

''(2) AGGREGATION RULE.—For purposes of this subsection, all policies issued with respect to the same taxpayer shall be treated as one policy.

''(h) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the requirements of this section, including regulations to prevent the avoidance of this section by providing long-term care insurance coverage under a life insurance contract and to provide for the proper allocation of amounts between the long-term care and life insurance portions of a contract.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 79 is amended by inserting after the item relating to section 7702A the following new item:

''Sec. 7702B. Treatment of long-term care insurance.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to policies issued after December 31, 1995. Solely for purposes of the preceding sentence, a policy issued prior to January 1, 1996, that satisfies the requirements of a qualified long-term care insurance policy as set forth in section 7702B(b) shall, on and after January 1, 1996, be treated as having been issued after December 31, 1995.

(2) TRANSITION RULE.—If, after the date of enactment of this Act and before January 1, 1996, a policy providing for long-term care insurance coverage is exchanged solely for a qualified long-term care insurance policy (as defined in section 7702B(b)), no gain or loss shall be recognized on the exchange. If, in addition to a qualified long-term care insurance policy, money or other property is received in the exchange, then any gain shall be recognized to the extent of the sum of the money and the fair market value of the other property received. For purposes of this paragraph, the cancellation of a policy providing for long-term care insurance coverage and reinvestment of the cancellation proceeds in a qualified long-term care insurance policy within 60 days thereafter shall be treated as an exchange.

(3) ISSUANCE OF CERTAIN RIDERS PERMITTED.—For purposes of determining whether section 7702 or 7702A of the Internal Revenue Code of 1986 applies to any contract, the issuance, whether before, on, or after December 31, 1995, of a rider on a life insurance contract providing long-term care insurance coverage shall not be treated as a modification or material change of such contract.

SEC. 103. TREATMENT OF BENEFITS UNDER QUALIFIED LONG-TERM CARE POLICIES.

(a) EXCLUSION FROM COBRA CONTINUATION REQUIREMENTS.—Subparagraph (A) of section 4980B(f)(2) of the Internal Revenue Code of 1986 (defining continuation coverage) is amended by adding at the end the following new sentence: ''The coverage shall not include coverage for qualified long-term care services (as defined in section 213(f)).''.

(b) BENEFITS INCLUDED IN CAFETERIA PLANS.—Section 125(f) of the Internal Revenue Code of 1986 (defining qualified benefits) is amended by adding at the end the following new sentence: ''Such term includes coverage under a qualified long-term care insurance policy (as defined in section 7702B(b)) which is includible in gross income only because it exceeds the dollar limitation of section 105(c)(2).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 104. TAX RESERVES FOR QUALIFIED LONG-TERM CARE INSURANCE POLICIES.

(a) IN GENERAL.—Subparagraph (A) of section 807(d)(3) of the Internal Revenue Code of 1986 (relating to tax reserve methods) is amended by redesignating clause (iv) as clause (v) and by inserting after clause (iii) the following new clause:

''(iv) QUALIFIED LONG-TERM CARE INSURANCE POLICIES.—In the case of any qualified long-term care insurance policy (as defined in section 7702B(b))—

''(I) the reserve method prescribed by the National Association of Insurance Commissioners which covers such policy (as of the date of issuance); or

''(II) if no reserve method has been prescribed by the National Association of Insurance Commissioners which covers such policy, a 1-year full preliminary term method.''.

(b) CONFORMING AMENDMENT.—Clause (v) of section 807(d)(3)(A) of the Internal Revenue Code of 1986 (relating to tax reserve methods) is amended in the matter preceding subclause (I) by striking ''(ii) or (iii)'' and inserting ''(ii), (iii), or (iv)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 105. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.

(a) GENERAL RULE.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, any amount distributed to an individual under a life insurance contract on the life of an insured who is a terminally ill individual (as defined in paragraph (3)) shall be treated as an amount paid by reason of the death of such insured.

''(2) NECESSARY CONDITIONS.—

''(A) Paragraph (1) shall not apply to any distribution unless—

''(i) the distribution is not less than the present value (determined under subparagraph (B)) of the reduction in the death benefit otherwise payable in the event of the death of the insured, and

''(ii) the percentage derived by dividing the cash surrender value of the contract, if any, immediately after the distribution by the cash surrender value of the contract immediately before the distribution is equal to or greater than the percentage derived by dividing the death benefit immediately after the distribution by the death benefit immediately before the distribution.

''(B) The present value of the reduction in the death benefit occurring by reason of the distribution shall be determined by—

''(i) using as the discount rate a rate not in excess of the highest rate set forth in subparagraph (C), and

''(ii) assuming that the death benefit (or the portion thereof) would have been paid at the end of a period that is no more than the insured's life expectancy from the

date of the distribution or 12 months, whichever is shorter.

''(C) RATES.—The rates set forth in this subparagraph are the following:

''(i) the 90-day Treasury bill yield,

''(ii) the rate described as Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto, for the calendar month ending 2 months before the date on which the rate is determined,

''(iii) the rate used to compute the cash surrender values under the contract during the applicable period plus 1 percent per annum, and

''(iv) the maximum permissible interest rate applicable to policy loans under the contract.

''(3) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who, as determined by the insurer on the basis of an acceptable certification by a licensed physician, has an illness or physical condition which can reasonably be expected

to result in death within 12 months of the date of certification.

''(4) APPLICATION OF SECTION 72(e)(10).—For purposes of section 72(e)(10) (relating to the treatment of modified endowment contracts), section 72(e)(4)(A)(i) shall not apply to distributions described in paragraph (1).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1995.

SEC. 106. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

''(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

''(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract which provides for a distribution to an individual upon the insured becoming a terminally ill individual (as defined in section 101(g)(3)).''.

(b) DEFINITIONS OF LIFE INSURANCE AND MODIFIED ENDOWMENT CONTRACTS.—Paragraph (5)(A) of section 7702(f) is amended by striking ''or'' at the end of clause (iv), by redesignating clause (v) as clause (vi), and by inserting after clause (iv) the following new clause:

''(v) any qualified accelerated death benefit rider (as defined in section 818(g)), or''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to contracts issued after December 31, 1995.

(2) TRANSITIONAL RULE.—For purposes of determining whether section 7702 or 7702A of the Internal Revenue Code of 1986 applies to any contract, the issuance, whether before, on, or after December 31, 1995, of a rider on a life insurance contract permitting the acceleration of death benefits

(as described in section 101(g) of such Code) shall not be treated as a modification or material change of such contract.

TITLE II—STANDARDS FOR LONG-TERM CARE INSURANCE

SEC. 201. POLICY REQUIREMENTS.

(a) APPLICATION OF CONSUMER PROTECTION PROVISIONS TO QUALIFIED POLICIES.—Section 7702B(b)(1)(B) (as added by section 102) is amended by inserting ''and of subsection (f)'' after ''and (5)''.

(b) CONSUMER PROTECTION PROVISIONS.—Section 7702B (as added by section 102) is amended by redesignating subsection (f) as subsection (h) and by inserting after subsection (e) the following new subsections:

''(f) CONSUMER PROTECTION PROVISIONS.—

''(1) IN GENERAL.—The requirements of this subsection are met with respect to any long-term care insurance policy if the policy meets—

''(A) the requirements of the model regulation and model Act described in paragraph (2),

''(B) the disclosure requirement of paragraph (3),

''(C) the requirements relating to nonforfeitability under paragraph (4), and

''(D) the requirements relating to rate stabilization under paragraph (5).

''(2) REQUIREMENTS OF MODEL REGULATION AND ACT.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any long-term care insurance policy if such policy meets—

''(i) MODEL REGULATION.—The following requirements of the model regulation:

''(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

''(II) Section 7B (relating to prohibitions on limitations and exclusions).

''(III) Section 7C (relating to extension of benefits).

''(IV) Section 7D (relating to continuation or conversion of coverage).

''(V) Section 7E (relating to discontinuance and replacement of policies).

''(VI) Section 8 (relating to unintentional lapse).

''(VII) Section 9 (relating to disclosure), other than section 9F thereof.

''(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

''(IX) Section 11 (relating to minimum standards).

''(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

''(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

''(ii) MODEL ACT.—The following requirements of the model Act:

''(I) Section 6C (relating to preexisting conditions).

''(II) Section 6D (relating to prior hospitalization).

''(B) DEFINITIONS.—For purposes of this paragraph—

''(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted in January of 1993).

''(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

''(3) TAX DISCLOSURE REQUIREMENT.—The requirement of this paragraph is met with respect to

any long-term care insurance policy if such policy meets the requirements of section 4980C(d)(1).

''(4) NONFORFEITURE REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any long-term care insurance policy, if the issuer of such policy offers to the policyholder, including any group policyholder, a nonforfeiture provision.

''(B) REQUIREMENTS OF PROVISION.—The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

''(i) The nonforfeiture provision shall be appropriately captioned.

''(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying policies approved by the Secretary for the same policy form.

''(iii) The nonforfeiture provision shall provide at least one of the following:

''(I) Reduced paid-up insurance.

''(II) Extended term insurance.

''(III) Shortened benefit period.

''(IV) Other similar offerings approved by the Secretary.

''(5) RATE STABILIZATION.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any long-term care insurance policy, including any group master policy, if—

''(i) such policy contains the minimum rate guarantees specified in subparagraph (B), and

''(ii) the issuer of such policy meets the requirements specified in subparagraph (C).

''(B) MINIMUM RATE GUARANTEES.—The minimum rate guarantees specified in this subparagraph are as follows:

''(i) Rates under the policy shall be guaranteed for a period of at least 3 years from the date of issue of the policy.

''(ii) After the expiration of the 3-year period required under clause (i), any rate increase shall be guaranteed for a period of at least 2 years from the effective date of such rate increase.

''(iii) In the case of any individual age 75 or older who has maintained coverage under a long-term care insurance policy for 10 years, rate increases under such policy shall not exceed 10 percent in any 12-month period.

''(C) INCREASES IN PREMIUMS.—The requirements specified in this subparagraph are as follows:

''(i) IN GENERAL.—If an issuer of any long-term care insurance policy, including any group master policy, plans to increase the premium rates for a policy, such issuer shall, at least 90 days before the effective date of the rate increase, offer to each individual policyholder under such policy the option to remain insured under the policy at a reduced level of benefits which maintains the premium rate at the rate in effect

on the day before the effective date of the rate increase.

''(ii) INCREASES OF MORE THAN 50 PERCENT.—If an issuer of any long-term care insurance policy, including any group master policy, increases premium rates for a policy by more than 50 percent in any 3-year period—

''(I) in the case of a group master long-term care insurance policy, the issuer shall discontinue issuing all group master long-term care insurance policies in any State in which the issuer issues such policy for a period of 2 years from the effective date of such premium increase; and

''(II) in the case of an individual long-term care insurance policy, the issuer shall discontinue issuing all individual long-term care policies in any State in which the issuer issues such policy for a period of 2 years from the effective date of such premium increase.

This clause shall apply to any issuer of long-term care insurance policies or any other person that purchases or otherwise acquires any long-term care insurance policies from another issuer or person.

''(D) MODIFICATIONS OR WAIVERS OF REQUIREMENTS.—The Secretary may modify or waive any of the requirements under this paragraph if—

''(i) such requirements will adversely affect an issuer's solvency;

''(ii) such modification or waiver is required for the issuer to meet other State or Federal requirements;

''(iii) medical developments, new disabling diseases, changes in long-term care delivery, or a new method of financing long-term care will result in changes to mortality and morbidity patterns or assumptions;

''(iv) judicial interpretation of a policy's benefit features results in unintended claim liabilities; or

''(v) in the case of a purchase or other acquisition of long-term care insurance

policies of an issuer or other person, the continued sale of other long-term care insurance policies by the purchasing issuer or person is in the best interests of individual consumers.

''(g) LONG-TERM CARE INSURANCE POLICY DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'long-term care insurance policy' means any product which is advertised, marketed, or offered as long-term care insurance (as defined in paragraph (2)).

''(2) LONG-TERM CARE INSURANCE.—

''(A) IN GENERAL.—The term 'long-term care insurance' means any insurance policy or rider—

''(i) advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care serv-

ices provided in a setting other than an acute care unit of a hospital; and

''(ii) issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization to the extent such organizations are otherwise authorized to issue life or health insurance.

Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance and includes a policy or rider which provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

''(B) EXCLUSIONS.—The term 'long-term care insurance' shall not include—

''(i) any insurance policy which is offered primarily to provide basic coverage to supplement coverage under the medicare program under title XVIII of the Social Security Act, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement coverage,

major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage; or

''(ii) life insurance policies—

''(I) which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness or medical conditions requiring extraordinary medical intervention or permanent institutional confinement;

''(II) which provide the option of a lump-sum payment for such benefits; and

''(III) under which neither such benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.''.

SEC. 202. ADDITIONAL REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

(a) IN GENERAL.—Chapter 43 is amended by adding at the end the following new section:

"SEC. 4980C. FAILURE TO MEET REQUIREMENTS FOR LONG-TERM CARE INSURANCE POLICIES.

''(a) GENERAL RULE.—There is hereby imposed on the issuer of any long-term care insurance policy with respect to which any requirement of subsection (c) or (d) is not met a tax in the amount determined under subsection (b).

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The amount of the tax imposed by subsection (a) shall be $100 per policy for each day any requirement of subsection (c) or (d) is not met with respect to the policy.

''(2) WAIVER.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of the tax would be excessive relative to the failure involved.

''(c) ADDITIONAL RESPONSIBILITIES.—The requirements of this subsection with respect to any long-term care insurance policy are as follows:

''(1) REQUIREMENTS OF MODEL PROVISIONS.—

''(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

''(i) Section 13 (relating to application forms and replacement coverage).

''(ii) Section 14 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expended as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable pre-existing condition.

''(iii) Section 20 (relating to filing requirements for marketing).

''(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than section 21C(1) and 21C(6) thereof, except that—

''(I) in addition to such requirements, no person shall, in selling or offering to sell a long-term care insurance policy, misrepresent a material fact; and

''(II) no such requirements shall include a requirement to inquire or

identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

''(v) Section 22 (relating to appropriateness of recommended purchase).

''(vi) Section 24 (relating to standard format outline of coverage).

''(vii) Section 25 (relating to requirement to deliver shopper's guide).

''(B) MODEL ACT.—The following requirements of the model Act must be met:

''(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

''(ii) Section 6G (relating to outline of coverage).

''(iii) Section 6H (relating to requirements for certificates under group plans).

''(iv) Section 6I (relating to policy summary).

''(v) Section 6J (relating to monthly reports on accelerated death benefits).

''(vi) Section 7 (relating to incontestability period).

''(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(f)(2)(B).

''(2) DELIVERY OF POLICY.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the issuer shall deliver to the applicant (or policyholder or certificate-holder) the policy (or certificate) of insurance not later than 30 days after the date of the approval.

''(3) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificate-holder (or representative)—

''(A) provide a written explanation of the reasons for the denial, and

''(B) make available all information directly relating to such denial.

''(d) DISCLOSURE.—The requirements of this subsection are met with respect to any long-term care insurance policy if either of the following statements, whichever

is applicable, is prominently displayed on the front page of the policy and in the outline of coverage required under subsection (c)(1)(B)(ii):

''(1) A statement that: 'This policy is intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986.'.

''(2) A statement that: 'This policy is not intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986.'.

''(e) LONG-TERM CARE INSURANCE POLICY DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'long-term care insurance policy' means any product which is advertised, marketed, or offered as long-term care insurance (as defined in paragraph (2)).

''(2) LONG-TERM CARE INSURANCE.—

''(A) IN GENERAL.—The term 'long-term care insurance' means any insurance policy or rider—

''(i) advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each cov-

ered person on an expense incurred, indemnity, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital; and

''(ii) issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization to the extent such organizations are otherwise authorized to issue life or health insurance.

Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance and includes a policy or rider which provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

''(B) EXCLUSIONS.—The term 'long-term care insurance' shall not include—

''(i) any insurance policy which is offered primarily to provide basic coverage to

supplement coverage under the medicare program under title XVIII of the Social Security Act, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage; or

''(ii) life insurance policies—

''(I) which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness or medical conditions requiring extraordinary medical intervention or permanent institutional confinement;

''(II) which provide the option of a lump-sum payment for such benefits; and

''(III) under which neither such benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.''.

(b) CONFORMING AMENDMENT.—The table of sections for chapter 43 is amended by adding at the end the following new item:

''Sec. 4980C. Failure to meet requirements for long-term care insurance policies.''.

SEC. 203. COORDINATION WITH STATE REQUIREMENTS.

Nothing in this subtitle shall be construed as preventing a State from applying standards that provide greater protection of policyholders of long-term care insurance policies (as defined in section 7702B(g) of the Internal Revenue Code of 1986).

SEC. 204. UNIFORM LANGUAGE AND DEFINITIONS.

(a) IN GENERAL.—The National Association of Insurance Commissioners shall not later than January 1, 1995, promulgate standards for the use of uniform language and definitions in long-term care insurance policies (as defined in section 7702B(g) of the Internal Revenue Code of 1986).

(b) VARIATIONS.—Standards under subsection (a) may permit the use of nonuniform language to the extent required to take into account differences among States in the licensing of nursing facilities and other providers of long-term care.

SEC. 205. EFFECTIVE DATES.

(a) SECTION 201.—The amendments made by section 201 shall apply to contracts issued after December 31, 1995.

(b) SECTION 202.—The amendments made by section 202 shall apply to actions taken after December 31, 1995.

TITLE III—INCENTIVES TO ENCOURAGE THE PURCHASE OF PRIVATE INSURANCE

SEC. 301. PUBLIC INFORMATION AND EDUCATION PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish a program designed to educate individuals regarding—

(1) the risk of incurring catastrophic long-term care costs;

(2) the coverage or lack of coverage of such costs through Federal programs;

(3) the importance of planning for such costs; and

(4) the benefits of securing long-term care insurance coverage.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

SEC. 302. ASSETS OR RESOURCES DISREGARDED UNDER THE MEDICAID PROGRAM.

(a) MEDICAID ESTATE RECOVERIES.—

(1) IN GENERAL.—Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) is amended—

(A) in paragraph (1), by striking subparagraph (C);

(B) in paragraph (3), by striking ''(other than paragraph (1)(C))''; and

(C) in paragraph (4)(B), by striking ''(and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies)''.

(2) EFFECTIVE DATE.—Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) shall be applied and administered as if the provisions stricken by paragraph (1) had not been enacted.

(b) REPORTING REQUIREMENTS FOR CERTAIN ASSET PROTECTION PROGRAMS.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

''(aa)(1) The Secretary shall not approve any State plan amendment providing for an asset protection program (as described in paragraph (2)) unless the State requires all insurers participating in such program to submit reports to the State and the Secretary at such times, and

containing such information, as the Secretary determines appropriate. The information included in the reports required to be submitted under the preceding sentence shall be submitted in accordance with the data standards established by the Secretary under paragraph (3).

''(2) An asset protection program described in this paragraph is a program under which an individual's assets and resources are disregarded for purposes of the program under this title—

''(A) to the extent that payments are made under a long-term care insurance policy; or

''(B) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

''(3)(A) Not later than 30 days after the date of the enactment of this Act, the Secretary shall select data standards for the information required to be included in reports submitted in accordance with paragraph (1). Such data standards shall be selected from the data standards included in the Long-term Care Insurance Uniform Data Set developed by the University of Maryland Center on Aging and Laguna Research Associates, and used by the States of California, Connecticut, Indiana, and New York for reports submitted by insurers under the asset protection programs conducted by such States.

''(B) The Secretary shall modify the standards selected under subparagraph (A) as the Secretary determines appropriate.''.

SEC. 303. DISTRIBUTIONS FROM INDIVIDUAL RETIREMENT ACCOUNTS FOR THE PURCHASE OF LONG-TERM CARE INSURANCE COVERAGE.

(a) EXCLUSION FROM GROSS INCOME FOR CERTAIN INDIVIDUALS.—Subsection (d) of section 408 of the Internal Revenue Code of 1986 (relating to tax treatment of distributions from individual retirement accounts) is amended by adding at the end the following new paragraph:

''(8) DISTRIBUTIONS TO PURCHASE LONG-TERM CARE INSURANCE.—

''(A) IN GENERAL.—Paragraph (1) shall not apply to the applicable percentage of any amount paid or distributed out of an individual retirement account or individual retirement annuity to the individual for whose benefit the account or annuity is maintained if—

''(i) the individual has attained age 59½ by the date of the payment or distribution, and

''(ii) the entire amount received (including money and any other property) is

used within 90 days to purchase a qualified long-term care insurance policy (as defined in section 7702B(b)) for the benefit of the individual or the spouse of the individual (if the spouse has attained age 59½ by the date of the payment or distribution).

''(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the term 'applicable percentage' means 100 percent reduced (but not below zero) by the number of percentage points determined by dividing—

''(i) the amount by which the taxpayer's adjusted gross income exceeds the minimum amount, by

''(ii) the difference between the maximum amount and the minimum amount.

''(C) MINIMUM AND MAXIMUM AMOUNTS.—

''(i) IN GENERAL.—For purposes of subparagraph (B), the minimum amount is $45,000 and the maximum amount is $100,000.

''(ii) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning

in any calendar year after 1996, each of the dollar amounts under clause (i) shall be increased by an amount equal to—

''(I) the dollar amount, multiplied by

''(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, by substituting 'calendar year 1995' for 'calendar year 1992' in subparagraph (B) thereof.

''(iii) ROUNDING.—If any amount determined under clause (ii) is not a multiple of $10, the amount shall be rounded to the nearest multiple of $10 (or if the amount is a multiple of $5 and not a multiple of $10, the amount shall be increased to the next multiple of $10).

''(iv) SPECIAL RULE.—In the case of a married individual filing a separate return, the minimum and maximum amounts with respect to such individual shall be 50 percent of the amounts otherwise in effect for the taxable year.''.

(b) NO PENALTY FOR DISTRIBUTIONS.—

(1) IN GENERAL.—Subparagraph (B) of section 72(t)(2) of the Internal Revenue Code of 1986 (relating to distributions from qualified retirement plans not subject to 10 percent additional tax) is amended to read as follows:

''(B) MEDICAL EXPENSES.—

''(i) IN GENERAL.—Distributions made to the employee (other than distributions described in clause (ii) or subparagraph (A) or (C)) to the extent such distributions do not exceed the amount allowable as a deduction under section 213 to the employee for amounts paid during the taxable year for medical care (determined without regard to whether the employee itemizes deductions for such taxable year).

''(ii) CERTAIN DISTRIBUTIONS TO PURCHASE LONG-TERM CARE INSURANCE.—Distributions made to the taxpayer out of an individual retirement plan if the entire amount received (including money and any other property) is used within 90 days to purchase a qualified long-term care insurance policy (as defined in section

7702B(b)) for the benefit of the individual or the spouse of the individual.''.

(2) CONFORMING AMENDMENT.—Subparagraph (A) of section 72(t)(3) of the Internal Revenue Code of 1986 is amended by striking ''(B)'' and inserting ''(B)(i)''.

(c) DEDUCTION FOR EXPENSES TO PURCHASE A QUALIFIED LONG-TERM CARE INSURANCE POLICY.—

(1) IN GENERAL.—Paragraph (8) of section 408(d) of the Internal Revenue Code of 1986 (relating to distributions from individual retirement accounts to purchase long-term care insurance), as added by subsection (a), is amended by adding at the end the following new subparagraph:

''(D) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for expenses incurred to purchase a qualified long-term care insurance policy (as defined in section 7702B(b)) using amounts paid or distributed out of an individual retirement account or individual retirement annuity in accordance with this paragraph.''.

(2) CONFORMING AMENDMENT.—Clause (ii) of section 213(d)(1)(D) of the Internal Revenue Code of 1986 (relating to definition of medical care), as

added by section 101(a), is amended by striking ''section 7702(d)(4)'' and inserting ''section 408(d)(8)(D) or section 7702(d)(4)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

TITLE IV—IMPROVED PUBLIC SAFETY NET FOR LONG-TERM CARE

SEC. 401. REFERENCES IN TITLE.

Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

SEC. 402. SPENDDOWN ELIGIBILITY FOR NURSING FACILITY RESIDENTS.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i) (42 U.S.C. 1396a(a)(10)(A)(i)) is amended—

(1) by striking ''or'' at the end of subclause (VI);

(2) by striking the semicolon at the end of subclause (VII) and inserting '', or''; and

(3) by inserting after subclause (VII) the following new subclause:

''(VIII) who are individuals who would meet the income and resource requirements of the appropriate State plan described in subclause (I) or the supplemental security income program (as the case may be), if incurred expenses for medical care as recognized under State law were deducted from income;''.

(b) LIMITATION TO BENEFITS FOR NURSING FACILITY SERVICES.—Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (F)—

(1) by striking ''and (XIII)'' and inserting ''(XIII)''; and

(2) by inserting before the semicolon at the end the following: '', and (XIV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance for nursing facility services''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply with respect to a State as of January 1, 1996.

SEC. 403. INCREASE IN PERSONAL NEEDS ALLOWANCE FOR INSTITUTIONALIZED INDIVIDUALS.

(a) IN GENERAL.—Section 1902(q)(2) (42 U.S.C. 1396a(q)(2)) is amended—

(1) by striking ''$30'' and inserting ''$50''; and

(2) by striking ''$60'' and inserting ''$80''.

(b) FEDERAL REIMBURSEMENT FOR REDUCTIONS IN STATE FUNDS ATTRIBUTABLE TO INCREASED PERSONAL NEEDS ALLOWANCE.—Section 1903(a) (42 U.S.C. 1396b(a)) is amended—

(1) by striking ''plus'' at the end of paragraph (6);

(2) by striking the period at the end of paragraph (7) and inserting ''; plus''; and

(3) by adding at the end the following new paragraph:

''(8) an amount equal to 100 percent of the difference between the amount of expenditures made by the State for nursing facility services and services in an intermediate care facility for the mentally retarded during the quarter and the amount of expenditures that would have been made by the State for such services during the quarter based on the personal needs allowance in effect in the State under section 1902(q) as of April 30, 1994.''.

(c) CONFORMING SSI PERSONAL NEEDS ALLOWANCE.—Section 1611(e)(1)(B) (42 U.S.C. 1382(e)(1)(B)) is amended—

(1) in clauses (i) and (ii)(I), by striking ''$360'' and inserting ''$600''; and

(2) in clause (iii), by striking ''$720'' and inserting ''$1,200''.

(d) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to months beginning with January 1996.

SEC. 404. INCREASED RESOURCE DISREGARD FOR NURSING FACILITY RESIDENTS.

(a) INCREASED DISREGARD FOR RESOURCES.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) by striking ''and'' at the end of paragraph (61);

(2) by striking the period at the end of paragraph (62) and inserting ''; and''; and

(3) by inserting after paragraph (62) the following new paragraph:

''(63) provide that, in determining the eligibility of any unmarried individual who is an inpatient in a nursing facility or intermediate care facility for the mentally retarded, the first $8,000 of resources may, at the option of the State, be disregarded;''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to months beginning with January 1996.

SEC. 405. INFORMING NURSING HOME RESIDENTS ABOUT AVAILABILITY OF ASSISTANCE FOR HOME AND COMMUNITY-BASED SERVICES.

(a) IN GENERAL.—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by section 404(a), is amended—

(1) by striking ''and'' at the end of paragraph (62);

(2) by striking the period at the end of paragraph (63) and inserting ''; and''; and

(3) by inserting after paragraph (63) the following new paragraph:

''(64) provide that an individual who is a resident (or who is applying to become a resident) of a nursing facility or intermediate care facility for the mentally retarded (or a designated representative of such an individual) shall receive, at the time of application for medical assistance and periodically thereafter, information on the range of home and community-based services for which assistance is available in the State either under the plan under this title or any other public program.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to quarters beginning on or after January 1, 1996.

SEC. 406. ESTABLISHMENT OF STATE PROGRAMS FURNISHING HOME AND COMMUNITY-BASED SERVICES TO CERTAIN INDIVIDUALS WITH DISABILITIES.

(a) STATE PLAN REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by sections 404(a) and 405(a), is amended—

(1) by striking ''and'' at the end of paragraph (63);

(2) by striking the period at the end of paragraph (64) and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(65) at the option of the State, provide for the establishment of a program under which the State furnishes covered home and community-based services (as defined in section 1931(c)(1)) to eligible individuals with disabilities (as defined in section 1931(c)(2)) in accordance with section 1931.''.

(b) ESTABLISHMENT OF PROGRAM.—Title XIX (42 U.S.C. 1936 et seq.) is amended by redesignating section

1931 as section 1932 and by inserting after section 1930 the following new section:

''HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES

''SEC. 1931. (a) ESTABLISHMENT OF PROGRAM.—Each State with an approved State plan under this title may establish a program under which the State furnishes covered home and community-based services to eligible individuals with disabilities in accordance with this section to the extent that such services are not provided under any other Federal or State program.

''(b) ASSESSMENTS.—

''(1) INITIAL ASSESSMENT.—A State program under this section shall provide for an initial assessment of all individuals who appear to have a reasonable likelihood of being an eligible individual with disabilities. Such an assessment may be conducted by a qualified case manager or by any other person or entity designated by the State under criteria specified by the Secretary.

''(2) INITIAL ASSESSMENT DESCRIBED.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), an initial assessment under this paragraph shall be conducted using a uniform protocol specified by the Secretary and shall include an assessment of an individual's—

''(i) ability or inability to perform any activities of daily living;

''(ii) health status;

''(iii) mental status;

''(iv) current living arrangement; and

''(v) use of formal and informal long-term care support systems.

''(B) EXCEPTION.—If a State receives advance approval from the Secretary, such State may—

''(i) conduct an initial assessment under this paragraph using a protocol other than a uniform protocol specified by the Secretary under subparagraph (A); and

''(ii) collect information in addition to the information required under clauses (i) through (v) of subparagraph (A).

''(3) PERIODIC REASSESSMENT.—A State program under this section shall provide for periodic reassessments of any eligible individual with disabilities who is receiving covered home and community-based services under this section. Such periodic reassessments shall be conducted upon any significant change in an individual's condition that may affect the individual's need for such services, but at least

within the 6-month period following each assessment of the individual (or within such longer period as determined appropriate by the State in the case of an individual who is unlikely to have a change in condition that would affect the individual's need for services).

''(c) QUALIFIED CASE MANAGER.—

''(1) IN GENERAL.—A State program under this section shall assign a qualified case manager to any eligible individual with disabilities receiving covered home and community-based services under this section. Such qualified case manager shall perform the case management services specified in this subsection.

''(2) CARE PLAN.—A qualified case manager shall develop, or arrange for the development of, an individualized written plan of care for an eligible individual with disabilities based upon the assessments conducted under subsection (b). The qualified case manager shall develop the care plan in a timely manner in consultation with the individual or the individual's representative, the individual's family, and the individual's primary medical care provider, and in accordance with any criteria that may be specified

by the State, in consultation with the Secretary. At a minimum, the care plan shall identify—

''(A) the long-term problems and needs of the individual;

''(B) the mix of formal and informal services and support systems that are available to meet the long-term care needs of the individual;

''(C) the appropriate covered home and community-based services necessary to meet the long-term care needs of the individual;

''(D) the manner in which covered home and community-based services will be provided;

''(E) the manner in which covered home and community-based services will be integrated with services provided under any other Federal or State program; and

''(F) goals for the individual which, to the extent practicable, shall include goals that are measurable.

''(3) REVISIONS TO CARE PLAN.—A qualified case manager shall revise an individual's care plan as appropriate based on the assessments performed under subsection (b).

''(4) STATE GUIDELINES WITH RESPECT TO CARE PLANS.—

''(A) TAKING INTO ACCOUNT INFORMAL CARE.—A State may, at its option, provide guidelines permitting a qualified case manager to take into account the availability of informal care in determining the amount and array of covered home and community-based services made available to an eligible individual with disabilities under such individual's care plan.

''(B) COORDINATION.—A State shall provide guidelines for qualified case managers to integrate covered home and community-based services with other Federal and State programs in accordance with paragraph (2)(E).

''(5) PROVISION OF SERVICES.—

''(A) COVERED SERVICES.—The qualified case manager, in consultation with an eligible individual with disabilities or the individual's representative, such individual's family, and such individual's primary medical care provider, shall—

''(i) assist in the implementation of the care plan; and

''(ii) in a manner that is cost-effective and consistent with obtaining quality care, provide, or arrange for the provision of,

appropriate covered home and community-based services.

To the extent possible, the case manager shall comply with the choice of an individual with disabilities regarding which covered home and community-based services to receive and the providers who will furnish such services.

''(B) NONCOVERED SERVICES.—The State may require the qualified case manager to assist an eligible individual with disabilities in obtaining noncovered services, at the individual's own expense or through other programs that may be available.

''(6) CARE PLAN MONITORING.—The qualified case manager shall monitor the delivery of services to an eligible individual with disabilities, the quality of care provided, and the status of the individual.

''(d) QUALITY ASSURANCE AND SAFEGUARDS.—

''(1) QUALITY ASSURANCE.—A State shall ensure and monitor the quality of covered home and community-based services furnished to eligible individuals with disabilities by—

''(A) adopting standards which safeguard the health and safety of such individuals;

''(B) establishing minimum standards for qualified case managers and providers and enforcing those standards;

''(C) establishing minimum competency requirements for employees of qualified providers and developing systems for enforcing such competency requirements;

''(D) obtaining meaningful input from eligible individuals with disabilities through surveys or otherwise that measure the extent to which such individuals receive the covered home and community-based services described in the care plan and the extent to which such individuals are satisfied with such services;

''(E) participating in quality assurance activities; and

''(F) specifying the role of the State Long-Term Care Ombudsman (under the Older Americans Act of 1965) and the protection and advocacy system (established under section 142 of the Developmental Disabilities Assistance and Bill of Rights Act) of the State in assuring quality of services and protecting the rights of individuals with disabilities.

''(2) SAFEGUARDS.—

''(A) CONFIDENTIALITY.—The State shall provide safeguards which restrict the use or disclosure of information concerning individuals applying for or receiving covered home and community-based services under this section to purposes directly connected with the administration of the program.

''(B) SAFEGUARDS AGAINST ABUSE.—The State shall provide safeguards against physical, emotional, or financial abuse or exploitation in the provision of case management services and covered home and community-based services.

''(e) INDIVIDUAL CHOICE.—The acceptance of benefits under this section is a voluntary choice of the eligible individual with disabilities or the individual's representative. Nothing in this section shall be construed to require such an individual to accept the services available under this section, or to accept benefits under this section instead of entering a nursing facility or intermediate care facility for the mentally retarded. An eligible individual with disabilities shall not be denied covered home and community-based services under this section solely because the individual refuses to accept one such service, unless the failure to accept such service would make other services

ineffective or no alternative is available that is cost-effective and acceptable to the individual.

''(f) PAYMENT METHODS.—

''(1) IN GENERAL.—A State shall specify the payment methods and rates to be used to reimburse qualified providers and qualified case managers for services furnished under the State's program under this section. Methods of payment specified by the State may include reimbursement on a fee-for-service basis, prepayment on a capitation basis, or a combination of such methods. Payment rates specified by the State shall be sufficient to ensure that the requirements of section 1902(a)(30)(A) are satisfied. The State, at its option, may permit qualified case managers to negotiate rates with qualified providers.

''(2) PAYMENT IN FULL.—The State shall restrict payment for covered home and community-based services to qualified providers who agree to accept the payment rates specified by the State under paragraph (1) as payment in full for such services.

''(3) COST SHARING.—A State may impose nominal cost sharing charges for covered home and community-based services furnished to eligible individuals with disabilities whose family income (as de-

termined in accordance with section 1902(l)(3)(E)) exceeds 100 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(g) MAINTENANCE OF EFFORT.—A State program under this section must provide assurances that, in the case of an individual receiving medical assistance for home and community-based services under this title as of the date of the enactment of this section, the State will continue to make available (either under this title or otherwise) to such individual an appropriate level of assistance for home and community-based services, taking into account the level of assistance provided as of such date and the individual's need for home and community-based services.

''(h) DEFINITIONS.—For purposes of this section—

''(1) COVERED HOME AND COMMUNITY-BASED SERVICES.—

''(A) IN GENERAL.—The term 'covered home and community-based services' means case management services and other services

furnished by a qualified provider, including the following:

''(i) Personal assistance services.

''(ii) Homemaker and chore assistance.

''(iii) Respite services.

''(iv) Assistive devices.

''(v) Adult day services.

''(vi) Habilitation and rehabilitation.

''(vii) Skilled home health care services.

''(B) EXCLUSIONS AND LIMITATIONS.—The term 'covered home and community-based services' shall not include—

''(i) room and board;

''(ii) services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional care setting, as specified by the Secretary;

''(iii) items or services covered under a private insurance policy; or

''(iv) any services specified in a care plan which are not specified in subparagraph (A).

''(C) PERSONAL ASSISTANCE SERVICES.—The term 'personal assistance services' means services specified by the State as personal assistance services, and shall include at least hands-on and standby assistance, supervision, and cueing with activities of daily living.

''(2) ELIGIBLE INDIVIDUAL WITH DISABILITIES.—

''(A) IN GENERAL.—The term 'eligible individual with disabilities' means an individual with disabilities—

''(i)(I) whose family income (as determined in accordance with section 1902(l)(3)(E)) does not exceed the phase-in eligibility percentage (specified in subparagraph (C)) of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; and

''(II) whose resources (other than resources excluded pursuant to section 1613 (a) and (b)) are not more than $8,000 (or,

for a couple, the amount determined under section 1924 with respect to the spouses of institutionalized individuals); or

''(ii) who would meet the income and resource requirements under clause (i) if incurred expenses for services described in clauses (i) through (vii) of paragraph (1)(A) were deducted from income.

''(B) INDIVIDUALS EXCLUDED.—Notwithstanding subparagraph (A), no individual with disabilities shall be an eligible individual with disabilities for purposes of this section if—

''(i) such individual is eligible for services in a nursing facility or an intermediate care facility for the mentally retarded; and

''(ii) a qualified case manager estimates (under methods specified by the Secretary) that the cost of furnishing covered home and community-based services to the individual under this section would be higher than the cost of institutionalizing the individual.

''(C) PHASE-IN ELIGIBILITY PERCENTAGE.—For purposes of subparagraph (A), the

phase-in eligibility percentage for a calendar year shall be—

''(i) for calendar year 1997, 90 percent;

''(ii) for calendar year 1998, 110 percent;

''(iii) for calendar year 1999, 130 percent; and

''(iv) for calendar year 2000 and succeeding calendar years, 150 percent.

''(3) INDIVIDUAL WITH DISABILITIES.—

''(A) IN GENERAL.—The term 'individual with disabilities' means any individual who is described in any of the following categories of individuals:

''(i) INDIVIDUALS REQUIRING HELP WITH ACTIVITIES OF DAILY LIVING.—An individual of any age who—

''(I) requires hands-on or standby assistance, supervision, or cueing (as defined in regulations) to perform two or more activities of daily living (as defined in subparagraph (B)); and

''(II) is expected to require such assistance, supervision, or cueing over a period of at least 100 days.

''(ii) INDIVIDUALS WITH MODERATE COGNITIVE OR MENTAL IMPAIRMENT.—An individual of any age—

''(I) whose score, on any standard mental status protocol appropriate for measuring the individual's particular condition, as specified by the Secretary, indicates either moderate cognitive impairment or moderate mental impairment, or both;

''(II) who displays symptoms of one or more serious behavioral problems, contained on a list of such problems specified by the Secretary, that create a need for supervision to prevent harm to the individual or others; and

''(III) who is expected to meet the conditions of clause (i) or (ii) over a period of at least 100 days.

''(iii) INDIVIDUALS WITH SEVERE OR PROFOUND MENTAL RETARDATION.—An

individual of any age who has severe or profound mental retardation (as determined according to a protocol specified by the Secretary).

''(iv) SEVERELY DISABLED CHILDREN.—An individual under 6 years of age who—

''(I) has a severe disability or chronic medical condition,

''(II) but for receiving services under this section, would require institutionalization in a hospital, nursing facility, or intermediate care facility for the mentally retarded, and

''(III) is expected to have such disability or condition and require such services over a period of at least 100 days.

''(B) ACTIVITY OF DAILY LIVING.—The term 'activity of daily living' means any of the following:

''(i) Eating.

''(ii) Toileting.

''(iii) Dressing.

''(iv) Bathing.

''(v) Transferring.

''(vi) Continence.

''(4) QUALIFIED CASE MANAGER.—The term 'qualified case manager' means a person who—

''(A) provides case management services to an eligible individual with disabilities;

''(B) is not a relative of such individual;

''(C) has experience in—

''(i) assessing individuals' functional and cognitive impairment;

''(ii) establishing, periodically reviewing, and revising individual care plans or has been trained in such activities; and

''(iii) the provision of case management services to individuals such as eligible individuals with disabilities; and

''(D) meets such other standards established by the Secretary or the State which may include standards which assure—

''(i) the quality of case management services; and

''(ii) that individuals receiving case management services are not at risk of financial exploitation.

''(5) QUALIFIED PROVIDER.—The term 'qualified provider' means a provider who is licensed under State law or who meets other criteria as the Secretary or State may specify.

''(6) RELATIVE DEFINED.—The term 'relative' means an individual bearing a relationship to another individual who is described in paragraphs (1) through (8) of section 152(a) of the Internal Revenue Code of 1986.''.

(c) PAYMENT TO STATES.—

(1) IN GENERAL.—Section 1903(a) (42 U.S.C. 1396b(a)), as amended by section 403(b), is amended—

(A) by striking ''plus'' at the end of paragraph (7);

(B) by striking the period at the end of paragraph (8) and inserting ''; plus''; and

(C) by adding at the end the following new paragraph:

''(9) an amount equal to the Federal home and community-based services matching percentage (as defined in section 1905(t)) of the total amount expended during such quarter for covered home and community-based services furnished under section 1931.''.

(2) FEDERAL HOME AND COMMUNITY-BASED SERVICES MATCHING PERCENTAGE.—Section 1905 (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

''(t) The term 'Federal home and community-based services matching percentage' means, with respect to a State, the State's Federal medical assistance percentage (as defined in subsection (b)) increased by 20 percentage points, except that the Federal home and community-based services matching percentage shall in no case be less than 75 percent or more than 88 percent.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall be effective with respect to calendar quarters beginning on or after January 1, 1997.

SEC. 407. REPORTS BY THE SECRETARY ON CERTAIN ISSUES RELATING TO LONG-TERM CARE.

The Secretary shall submit a report to Congress annually on—

(1) the effectiveness of State programs to furnish home and community-based services to individuals with disabilities under section 1931 of the Social Security Act; and

(2) the growth and development of the market for long-term care insurance.

SEC. 408. REPORT BY THE SECRETARY ON LONG-TERM CARE SERVICES FOR CHRONICALLY ILL INDIVIDUALS.

(a) IN GENERAL.—Not later than July 1, 1997, the Secretary shall submit a report to Congress on the feasibility and cost of including long-term care services for chronically ill individuals as a benefit under a standard benefit package to be offered under a reformed health care system.

(b) CHRONICALLY ILL INDIVIDUAL.—The term ''chronically ill individual'' means an individual with a serious and persistent chronic health condition.

SEC. 409. CHRONIC CARE COMMISSION.

(a) ESTABLISHMENT.—There is established a commission to be known as the Chronic Care Commission (hereafter referred to in this section as the ''Commission'').

(b) MEMBERSHIP.—

(1) IN GENERAL.—The Commission shall consist of—

(A) the Secretary of Health and Human Services (hereafter referred to in this section as the ''Secretary''); and

(B) 10 other members to be appointed by the President, in consultation with the Majority and Minority Leaders of the House of Rep-

resentatives and the Senate, not later than 30 days after the date of the enactment of this section.

(2) CHAIR.—The Secretary shall serve as the Chair of the Commission.

(3) EXPERTISE.—The members of the Commission appointed under paragraph (1)(B) shall include representatives of—

(A) chronically ill individuals;

(B) health care providers who furnish—

(i) primary care services;

(ii) acute care services;

(iii) institutional services; and

(iv) home and community-based services;

(C) the health insurance industry; and

(D) Federal and State health programs.

(4) TERMS.—Members of the Commission shall be appointed for the life of the Commission. A vacancy on the Commission shall be filled in the manner in which the original appointment was made and shall be subject to any conditions which applied with respect to the original appointment.

(c) DUTIES.—Not later than July 1, 1997, the Commission shall submit to Congress legislative recommenda-

tions to simplify and improve chronic care services furnished to chronically ill individuals. Such recommendations shall—

(1) encourage health care providers to establish community based networks which furnish chronic care services to chronically ill individuals;

(2) result in a reduction in the growth of the cumulative costs of furnishing chronic care services to such individuals across time and setting;

(3) outline chronic care service delivery reform which simplifies systems for administration, financing, and delivery of such services to such individuals;

(4) identify barriers to integration of chronic care services as established by existing legislative, regulatory, and administrative practices; and

(5) provide for a private sector, community-based approach to furnishing chronic care services to such individuals.

(d) CONSULTATION WITH CERTAIN ENTITIES.—In developing its legislative recommendations under subsection (c), the Commission shall consult with qualified entities participating in the demonstration projects on acute and long-term care integration conducted by the Secretary under section 410.

(e) MEETINGS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Commission shall meet at the call of the Chair.

(2) INITIAL MEETING.—Not later than 30 days after the date on which all members of the Commission have been appointed, the Commission shall hold its first meeting.

(3) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(f) POWER OF THE COMMISSION TO HOLD HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purposes of this section.

(g) COMMISSION PERSONNEL MATTERS.—

(1) COMPENSATION OF MEMBERS.—Each member of the Commission who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission. All

members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(3) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(h) TERMINATION OF THE COMMISSION.—The Commission shall terminate 90 days after the date on which the Commission submits its legislative recommendations under subsection (c).

(i) DEFINITIONS.—For purposes of this section—

(1) CHRONIC CARE SERVICES.—The term ''chronic care services'' means a full range of individualized services for chronically ill individuals, including primary care, hospital, nursing home, and

community-based services which satisfy the functional, psychological, environmental, social, and medical needs of such individuals and which enable such individuals to optimize functional independence and well being.

(2) CHRONICALLY ILL INDIVIDUAL.—The term ''chronically ill individual'' means an individual with a serious and persistent chronic health condition.

(j) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this subsection shall remain available, without fiscal year limitation, until expended.

SEC. 410. DEMONSTRATION PROJECTS ON ACUTE AND LONG-TERM CARE INTEGRATION.

(a) PROJECTS AUTHORIZED.—Not later than January 1, 1996, the Secretary of Health and Human Services (hereafter referred to in this section as the ''Secretary'') shall begin to conduct demonstration projects under which qualified entities test the effectiveness of various approaches to financing and providing integrated acute and long-term care services to chronically ill individuals (as de-

fined in section 408(h)(2)) and individuals with disabilities (as defined in section 1931(h)(3) of the Social Security Act).

(b) DEMONSTRATION PROJECTS DESCRIBED.—Demonstration projects conducted under this section shall establish an approach to financing and providing integrated acute and long-term care services to chronically ill individuals and individuals with disabilities which—

(1) improves quality through—

(A) management of ongoing chronic conditions rather than treatment of episodes;

(B) increasing the competency of individuals furnishing care; and

(C) providing care which produces the best outcomes;

(2) increases the satisfaction of individuals receiving care by—

(A) offering unified care over the duration of an individual's condition;

(B) simplifying access and transfer procedures; and

(C) permitting such individuals to participate in decision making regarding their care; and

(3) contains cumulative costs by—

(A) managing costs as an individual's condition progresses;

(B) allowing providers of care to have control and flexibility; and

(C) financing and fostering prevention and functional independence.

(c) APPLICATIONS.—Each qualified entity desiring to conduct a demonstration project under this section shall submit an application at such time as the Secretary determines appropriate containing—

(1) assurances that the acute and long-term care services furnished by the entity to chronically ill individuals and individuals with disabilities under the demonstration project will cost less than if such services were furnished to such individuals other than under the demonstration project; and

(2) such other information as the Secretary determines appropriate.

(d) NUMBER AND DURATION OF DEMONSTRATION PROJECTS.—

(1) NUMBER.—The Secretary shall authorize not more than 7 demonstration projects under this section.

(2) DURATION.—A demonstration project under this section shall be conducted for a period of 7 years.

(e) EVALUATION AND REPORTS.—The Secretary shall evaluate the demonstration projects conducted under this section and shall submit to Congress—

(1) an interim report, not later than 3 years after the date on which the first demonstration project begins, describing the status of the demonstration projects; and

(2) a final report, not later than 1 year after the last of the demonstration projects is completed, evaluating the effectiveness of the demonstration projects.

(f) DEFINITION OF QUALIFIED ENTITY.—For purposes of this section, the term ''qualified entity'' means an entity meeting the eligibility criteria established by the Secretary.

(g) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this subsection

shall remain available, without fiscal year limitation, until expended.

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Calendar No. 453

103D CONGRESS
2D SESSION

S. 2122

A BILL

To improve the public and private financing of long-term care and to strengthen the public safety net for elderly and non-elderly disabled individuals who lack adequate protection against long-term care expenses, and for other purposes.

JUNE 7, 1994

Read the second time and placed on the calendar